DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Children and Family Services
CFS-149 (Rev. 02/2003)

STATE OF WISCONSIN

FAMILY HISTORY QUESTIONNAIRE
MEDICAL / GENETIC

USE BLACK INK ONLY

Use of form: Completion of this form meets the requirements of s. 48.425 (1)(am), Wis. Stats. Each birth parent, at the time parental rights are terminated, should complete this form. Personally identifiable information on this form is confidential and will be used only for identification purposes.

BIRTH PARENT COMPLETING THIS FORM IS THE: ☐ **BIRTH MOTHER** ☐ **BIRTH FATHER**

If you have questions about this form, call (608) 266-7163.

SECTION I INFORMATION ABOUT BIRTH PARENT AND CHILD PLACED FOR ADOPTION

Name - CHILD (Last, First, Middle)	Birthdate	Birthplace (City, State)
☐ Child born at home. Provide name and address of midwife, if attending.	☐ Child born in hospital. Provide name and address of attending physician.	
Name (Current) - BIRTH MOTHER (Last, First, Middle)	Name - Maiden (Last)	Birthdate
Address (Street, City, State, Zip Code)	Address - Permanent (Street, City, State, Zip Code)	
Name - BIRTH FATHER (Last, First, Middle)		Birthdate
Address (Street, City, State, Zip Code)	Address - Permanent (Street, City, State, Zip Code)	

☐ Yes ☐ No Are the birth parents related to each other in any way or do they have blood ties? If "Yes", specify relationship:

SECTION II REVIEWER OF INFORMATION

Name - Individual Providing Information on Behalf of Birth Parent	Address - Current (Street, City, State, Zip Code)	Relationship to Child
Name - Agency Staff Person **Reviewing** Questionnaire		
Name - Agency	Address - Agency (Street, City, State, Zip Code)	

SECTION III DESCRIBE BIRTH PARENT AND HIS / HER PARENTS

	Birth Parent	Your Mother	Your Father
Name (Last, First, Middle)			
Birthdate			
Height and weight			
Ethnic / national background			
Racial group (Check one)	☐ White (not Hispanic) ☐ Black (not Hispanic) ☐ Hispanic ☐ Alaskan Native ☐ American Indian Enrolled: ☐ Yes ☐ No Name of Tribe: ____________ ☐ Asian or Pacific Islander ☐ Other	☐ White (not Hispanic) ☐ Black (not Hispanic) ☐ Hispanic ☐ Alaskan Native ☐ American Indian Enrolled: ☐ Yes ☐ No Name of Tribe: ____________ ☐ Asian or Pacific Islander ☐ Other	☐ White (not Hispanic) ☐ Black (not Hispanic) ☐ Hispanic ☐ Alaskan Native ☐ American Indian Enrolled: ☐ Yes ☐ No Name of Tribe: ____________ ☐ Asian or Pacific Islander ☐ Other

	Birth Parent	Your Mother	Your Father
Education completed. Indicate highest grade or if attended special education classes.			
If dead, age at death and cause of death, if known.			
ARE YOU ADOPTED?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

SECTION IV DESCRIBE BIRTH PARENT'S BROTHERS AND SISTERS

List all siblings in order of birth. If dead, include age at death and cause, if known. Indicate if they are full, half or step-brothers and sisters. If additional space is needed, attach separate sheet.

Name - Current (Last, First, Middle) Maiden	Relationship	Birthdate	Height	Weight	Gender - Children (M=Male F=Female)	Age	Height	Weight
1.	☐ Full ☐ Half ☐ Step				a. ☐ M ☐ F			
					b. ☐ M ☐ F			
If sibling listed above is dead, provide age at death and cause of death, if known.					c. ☐ M ☐ F			
					d. ☐ M ☐ F			
2.	☐ Full ☐ Half ☐ Step				a. ☐ M ☐ F			
					b. ☐ M ☐ F			
If sibling listed above is dead, provide age at death and cause of death, if known.					c. ☐ M ☐ F			
					d. ☐ M ☐ F			
3.	☐ Full ☐ Half ☐ Step				a. ☐ M ☐ F			
					b. ☐ M ☐ F			
If sibling listed above is dead, provide age at death and cause of death, if known.					c. ☐ M ☐ F			
					d. ☐ M ☐ F			
4.	☐ Full ☐ Half ☐ Step				a. ☐ M ☐ F			
					b. ☐ M ☐ F			
If sibling listed above is dead, provide age at death and cause of death, if known.					c. ☐ M ☐ F			
					d. ☐ M ☐ F			
5.	☐ Full ☐ Half ☐ Step				a. ☐ M ☐ F			
					b. ☐ M ☐ F			
If sibling listed above is dead, provide age at death and cause of death, if known.					c. ☐ M ☐ F			
					d. ☐ M ☐ F			
6.	☐ Full ☐ Half ☐ Step				a. ☐ M ☐ F			
					b. ☐ M ☐ F			
If sibling listed above is dead, provide age at death and cause of death, if known.					c. ☐ M ☐ F			
					d. ☐ M ☐ F			

SECTION V DESCRIBE BIRTH PARENT'S GRANDPARENTS

Category	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Name - Current (Last, First, Middle)				
Height and weight				
Ethnic / national background				
Racial group (Check one)	☐ White (not Hispanic) ☐ Black (not Hispanic) ☐ Hispanic ☐ Alaskan Native ☐ American Indian Enrolled: ☐ Yes ☐ No Name of Tribe: __________ ☐ Asian or Pacific Islander ☐ Other	☐ White (not Hispanic) ☐ Black (not Hispanic) ☐ Hispanic ☐ Alaskan Native ☐ American Indian Enrolled: ☐ Yes ☐ No Name of Tribe: __________ ☐ Asian or Pacific Islander ☐ Other	☐ White (not Hispanic) ☐ Black (not Hispanic) ☐ Hispanic ☐ Alaskan Native ☐ American Indian Enrolled: ☐ Yes ☐ No Name of Tribe: __________ ☐ Asian or Pacific Islander ☐ Other	☐ White (not Hispanic) ☐ Black (not Hispanic) ☐ Hispanic ☐ Alaskan Native ☐ American Indian Enrolled: ☐ Yes ☐ No Name of Tribe: __________ ☐ Asian or Pacific Islander ☐ Other
Education completed. Indicate highest grade or if attended special education.				
If dead, age at death and cause of death, if known.				

SECTION VI DESCRIBE BIRTH PARENT'S OTHER CHILDREN

List in order of birth. Include pregnancy losses, stillbirths, and miscarriages. If dead, indicate age at death and cause, if known. If additional space is needed, attach separate sheets.

Name (Last, First, Middle)	Relationship To Child Placed For Adoption	Birthdate	Height	Weight	Health / Medical Problems	If Dead, Cause and Age at Death, if Known
1.	☐ Full ☐ Half ☐ Step					
2.	☐ Full ☐ Half ☐ Step					
3.	☐ Full ☐ Half ☐ Step					
4.	☐ Full ☐ Half ☐ Step					
5.	☐ Full ☐ Half ☐ Step					
6.	☐ Full ☐ Half ☐ Step					

SECTION VII MEDICAL / GENETIC HISTORY

Indicate by checking "YES" or "NO" if this child or any blood relatives ever had or now have the medical conditions listed. Complete the "Comments" section, indicating age when condition began and specific diagnosis and treatment; indicate if 'UNKNOWN". Indicate all relatives in terms of their relationship to birth parent as listed in the following code section.

CODE	IMMEDIATE FAMILY
BP	Birth parent
OC	Birth parent's other child

CODE	FEMALE RELATIVES
M	Birth parent's mother (child's grandmother)
S	Birth parent's sister (child's aunt)
NE	Birth parent's niece (child's cousin)
MGM	Birth parent's maternal grandmother (your mother's mother)
PGM	Birth parent's paternal grandmother (your father's mother)

CODE	MALE RELATIVES
F	Birth parent's father (child's grandfather)
B	Birth parent's brother (child's uncle)
NEP	Birth parent's nephew (child's cousin)
MGF	Birth parent's maternal grandfather (your mother's father)
PGF	Birth parent's paternal grandfather (your father's father)

Medical Condition	No	Do Not Know	If "Yes", Code(s)	Comments; i.e., age at onset, specific diagnosis and treatment. If additional space is needed, attach a separate sheet.
1. Glasses (near / farsighted, cross-eyed, astigmatic, etc.)				
2. Blindness or other visual problems; e.g., glaucoma, cataracts				
3. Tay-Sachs disease				
4. Deafness, hearing disabilities				
5. Speech problems				
6. Dental problems; e.g., missing or extra teeth				
7. Harelip (cleft lip)				
8. Cleft palate				
9. Learning disability, dyslexia or other disabilities				
10. Mental retardation				
11. Special education				
12. Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD)				
13. Down's syndrome				
14. Mental illness; e.g., bipolar disorder, schizophrenia, depression				
15. Suicide				
16. Emotional problems				

Medical Condition	No	Do Not Know	If "Yes", Code(s)	Comments; i.e., age at onset, specific diagnosis and treatment. If additional space is needed, attach a separate sheet.
17. Autism				
18. Frequent headaches ; e.g., tension, migraine				
19. Hydrocephalus (waterhead)				
20. Microcephalus (small head)				
21. Patches of hair of different color (pigment)				
22. Patches of skin of different color; e.g., pigment or white spots				
23. Birthmarks ; e.g., unusual configuration, size, or number				
24. Eczema, acne and other skin problems				
25. Bleeding problems or hemophilia				
26. Sickle cell anemia				
27. Hypertension or high blood pressure				
28. Stroke				
29. Heart attack (coronary)				
30. Congenital heart defect				
31. Spina bifida (open spine)				
32. Scoliosis (spinal curvature)				
33. Bone deformities or brittleness				
34. Arthritis				
35. Muscular dystrophy				
36. Muscle weakness				
37. Hernia				
38. Cancer (type, site, age)				
39. Cystic fibrosis				
40. Huntington's chorea				

Medical Condition	No	Do Not Know	If "Yes", Code(s)	Comments; i.e., age at onset, specific diagnosis and treatment. If additional space is needed, attach a separate sheet.
41. Multiple sclerosis				
42. Cerebral palsy				
43. Neuromuscular disorder; e.g., myasthenia gravis, Lou Gehrig's disease (ALS)				
44. Parkinson's disease				
45. Seizures, convulsions, epilepsy				
46. Diabetes (indicate if juvenile, or adult onset, insulin or non-insulin, dependency)				
47. Thyroid disorder				
48. Other hormone disorder				
49. Dwarfism or short stature				
50. Tuberculosis				
51. Respiratory or breathing problems				
52. Asthma, hay fever or allergies				
53. Allergies - food (specify)				
54. Allergies - medicine (specify)				
55. Kidney problems				
56. Chemical dependency - alcoholism				
57. Chemical dependency - other drugs (specify)				
58. Weight problems; e.g., obesity or anorexia				
59. Stomach problems or ulcers				
60. Hand abnormalities ; e.g., extra / missing / webbed fingers				
61. Feet abnormalities ; e.g., extra / missing / webbed toes				
62. Club foot				

Medical Condition	No	Do Not Know	If "Yes", Code(s)	Comments; i.e., age at onset, specific diagnosis and treatment. If additional space is needed, attach a separate sheet.
63. Miscarriages - If "YES", identify by number and cause, if known				
64. Stillbirths - If "Yes", identify by number and cause, if known				
65. Multiple births - Indicate if identical or non-identical				
66. Infertility - Unable to have children				
67. Left-handedness				
68. Hepatitis B carrier				
69. Other health problems, conditions or known diagnosis that has not been mentioned				
70. HIV (Human Immunodeficiency Virus) infection				
71. Do you have AIDS? (Acquired Immunodeficiency Syndrome)				

SECTION VIII AUTHORIZATION

I authorize the agency assisting in preparing this document to disclose the medical / genetic information in this document to the Circuit Court and the Wisconsin Department of Health and Family Services for use in preparing and maintaining the medical / genetic history required by law concerning my birth child named in Section I.

I further authorize that the medical / genetic information provided herein may be made available to my birth child, to any future guardians of my birth child, and future caretakers or medical providers for my birth child as permitted by law. This authorization includes information concerning HIV, AIDS, ARC, mental illness, developmental disabilities, and drug and alcohol abuse.

_____ _____

SIGNATURE - Birth Parent Date Signed

NOTE: In accordance with Wisconsin Statutes, s. 48.425 (1)(am), the following information should accompany this form, if available:

1. A report of any medical examination which either birth parent had within one year before the date of the petition.
2. A report describing the child's prenatal care and medical condition at birth.
3. The medical / genetic history of the child and any other relevant medical / genetic information.